Commonwealth of Virginia DMHMRSAS

# The Partnership Press

*Restructuring the Services System Through Regional Partnership Planning*

Mark R. Warner
Governor of Virginia

*A Monthly Publication*

James S. Reinhard, M.D.
Commissioner

**Department of Mental Health, Mental Retardation and Substance Abuse Services**
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**Virginia's Final Olmstead Report**

The Final Report of the Task Force to Develop an Olmstead Plan for Virginia, complete with 7 Appendices, was submitted September 15, 2003 to Governor Warner and the Chairmen of the Joint Commission on Health Care, Senate Finance Committee and House Appropriations Committee. To view the Report, which is in Microsoft Word format and Adobe Acrobat format, go to: www.olmsteadva.com. Should you require a hard copy of the report, disk or other alternative format, please contact Fran Sadler at fsadler@dmhmrsas.state.va.us. The Executive Summary of the Report is highlighted below.

**What is Olmstead?** It is an opinion of the Supreme Court of the United States that is binding on all state govemments.

- Olmstead v. L.C., 119 S. Ct. 2176 (1999), involved a challenge under Title II of the Americans With Disabilities Act (ADA), 42 U.S.C. § 12132, by two women with mental disabilities who lived in mental health facilities operated by the State of Georgia, but who wished to live in the community. The U.S. Supreme Court held that Georgia had violated the ADA by forcing these women to remain in a State mental hospital after their treating professionals had determined them to be ready for discharge.
- The Court held that a state is required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when:
  - The State's treatment professionals determine that such placement is appropriate;
  - The affected persons do not oppose such placement; and
  - The placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities.
- States must make reasonable changes in or modifications to programs to provide more integrated services to qualified individuals, unless doing so would "fundamentally alter" the services provided.
- People with disabilities who *want* to move to a more integrated environment must be given a choice to do so. The choice must be a meaningful one, driven by the unique needs and preferences of those individuals. Of course, Olmstead does not require people receiving services to move anywhere if they oppose moving, and it does not prohibit people from choosing less integrated settings.

**To Whom Does Olmstead Apply?**

- Although the Olmstead case involved two individuals with a mental disability, the decision also applies to persons with other types of disabilities who are covered under the ADA.
- The Olmstead decision has been widely interpreted as applying to individuals who live in state-operated institutional and similar environments, however it has also been construed to apply to individuals currently living in the community and at risk of placement in these environments.
- This Report is intentionally broad in its scope in order to assure that no one who is currently, or who in the future may be, affected directly by Olmstead is left out. Therefore, some of the recommendations in this Report apply to individuals who live in state-operated institutional and similar environments, and other recommendations apply to individuals at risk of placement in these environments, particularly those who are at clear risk of such placement. **(Continued on Page 2)**


**Why Should Virginia Act?**

- It is the right thing to do. People with disabilities must not be segregated on the back wards of hospitals and institutions. New treatments and technologies allow the vast majority of people with disabilities to be full participants in all aspects of life in Virginia. People with disabilities are parents, sons and daughters, brothers and sisters. Virginia must give direction and resources to an Olmstead Plan – a roadmap to making the Commonwealth truly "One Community."
- The ADA and the Court's interpretation of it in Olmstead are the law in this Country.

**How Will Virginia Get There?** By developing a blueprint for implementing the recommendations contained in this Report. For this to happen, State administrators, policy makers, and agency officials must work together, with people with disabilities and service providers, to consistently collaborate; make needed changes in practices, policies, regulations, and legislation; and assure sufficient funding to implement the recommendations contained in this Report.

- We challenge the Governor and the General Assembly to support all Virginians with disabilities by leading the implementation of these recommendations.
- Many recommendations can be implemented immediately at no additional cost because they require only administrative action. Other recommendations will require legislation, and still others will require substantial funding over the course of the next six years.
- The Task Force has identified over 20 State agencies responsible for implementing the recommendations in this Report. Sustained inter-agency collaboration and coordination are critical to the success of all implementation efforts.
- Each affected agency should be charged with identifying individuals who are living unwillingly and inappropriately in institutional and similar environments and those who are clearly at risk of such placement; informing them of their rights under Olmstead; arranging for them to move to or stay in more integrated settings; costing out all recommendations in this Report; implementing administrative actions that do not require legislation or funding; and preparing legislative and budget proposals for the Governor and the General Assembly to consider.
- People with disabilities and their family members must have maximum opportunities to participate in all implementation efforts.

These are elements essential to ensuring that the Commonwealth establishes and implements a system of services and supports that is responsive to the unique needs and preferences of individuals with disabilities and that the system is adequately funded.

**Recommendations**

There are 201 recommendations identified in the Final Report. Recommendations are first categorized by time frame (Immediate, Short, Medium or Long Term) and within each time frame are grouped under one of the following categories: General Assembly, Disability Commission, Governor/Cabinet, State Agencies or Joint Commission on Health Care. The Report contains a number of items for which DMHMRSAS is listed as the suggested responsible entity. One immediate Recommendation for the Department of Mental Health, Mental Retardation and Substance Abuse Services follows:

> *Use DMHMRSAS Regional Partnership Planning process to identify collaboration opportunities to enhance community ownership of/accountability for service delivery; evaluate/refine State policy/operational structure in the short term. (Page 32 of Report).*

DMHMRSAS is considered an integral entity in the implementation of Olmstead in Virginia; the recommendation to use the Regional Partnership Planning process as a model for how facilities and communities can better integrate services across the Commonwealth is one example of the Department's commitment to the principles of Olmstead.

Governor Warner, in supporting the work of Virginia's Olmstead Task Force, stated:

> "By outlining specific implementation strategies and responsible entities in your report, you have created a blueprint that I can follow as I go about making important policy and budget decisions."

In addition, Governor Warner stated that he would work with the Secretary of Health and Human Resources to:

- Establish a collaborative, multi-agency team to cost out recommendations in the report,
- Direct state agencies to implement administrative actions that do not require legislation or funding,
- Direct agencies to prepare legislation and budget proposals for his consideration, and
- Establish an Olmstead Oversight Advisory Committee, comprised of consumers, family members, advocates, and providers, to monitor implementation of the recommendations.

## An Example of Successful Partnerships: CVTC Opens Its Doors to the Kentucky Avenue Residence During Hurricane Isabel

**By Jackie Skirven, VA Beach Community Services Board**

*On September 18th, Hurricane Isabel plowed through Virginia with devastating force. The storm is blamed for the deaths of nine people and caused over 1.5 million Virginians to lose power. Over 16,000 Virginians filed into emergency shelters. Parts of Virginia received up to 12 inches of rain within 24 hours and the Chesapeake Bay experienced an 8.2-foot storm surge. President Bush declared Virginia a major disaster area. Damage to Virginia's power grid and infrastructure alone is estimated at $128 million. Virginians across the Commonwealth pulled together to weather out Isabel and help neighbors who needed assistance. The following story details the experience of the Kentucky Avenue Residence, a group home operated by Virginia Beach Community Services Board. Jackie Skirven, Supervisor for the home, shares her perspective on the experience:*

Monday morning, September 15th, 2003. Hurricane Isabel was heading toward the central east coast, and it was becoming clear that this storm was likely to do substantial damage to the Hampton Roads area. Eight medically fragile individuals with severe to profound mental retardation were completely unaware of discussions being held by managers of their program to evacuate them to safety. The evacuation plan in place consisted of evacuating to a hotel in Richmond, Virginia – but we suddenly realized that this would not meet such needs as hospital beds, pureed food and electricity to operate an oxygen concentrator. Our clients would not fare well if their daily routines were completely disrupted. So we talked about approaching a private long term care facility in the area, but this raised several questions. Would they allow us to bring our own staff and medications for people we serve? Did their back up generators have sufficient power to handle our needs? How would billing be affected? By Monday afternoon, agreement had been made between our Unit Director, DMHMRSAS and CVTC in Lynchburg to open a building not currently being used, and to provide beds and meals according to current menu plans. All authorized representatives were contacted and gave consent to our plan.

Tuesday afternoon, nine clients and ten staff were traveling across Virginia. As far as we knew, staff would be sleeping with the clients and we carried all needed supplies with us. This included medical/personal care supplies, special dishes and spoons, snack foods, five wheelchairs and a very important beanbag chair! A few of us arrived at CVTC about 7:15 pm, to be met by the director and several of her senior staff. When additional information was provided, we discovered that the available beds would not work for five of the clients. CVTC staff quickly retrieved hospital beds from their storage unit. They supplied all bedding; placed us in the building connected to their hospital by a breezeway and arranged three meals per day for the clients. When they realized that the few staff we had with us would quickly burn out if they were not able to have some respite, they offered the use of their parent cottage – which was much more convenient than the one hotel room we had taken. After several stops to meet the needs of the clients, and then getting lost, the remainder of the party did not arrive until 9:15 pm. CVTC staff were still on hand, making sure that we had everything we needed before they retired for the night. Because of all the help we had received, staff designed work schedules that maintained the usual routines for clients and gave staff time to rest.

During the six days that followed, every department in the hospital stopped by to welcome us and offer assistance. Our staff continually remarked how friendly everyone was and this was probably a major factor towards the teamwork that evolved. The facility itself, although old, provided all the necessities for a medically fragile population and all of the clients adjusted well, benefited from the mountain air, and returned to appreciative and relieved families. Staff, although ready to return to their own families, felt that this was a very positive experience and one that they would not mind repeating. ***Thank you CVTC!***

# Regional Updates

## Central Region

**Regional Activities:** The Regional Reinvestment Project Manager began work September 2, 2003. The Regional Competitive Procurement process was completed and contract signed with a vendor to establish a 6-bed 24/7 adult residential crisis stabilization/detox program. This program will be operational October 22, 2003. Eight regional enhanced/supportive services nursing home care beds are in the process of being established, some on a single facility/single bed basis and some potentially on a single facility/multi-bed basis. A regional Behavioral Team is being established which will assist individual CSBs/Authority to address particularly challenging consumers, many of which have co-occurring disorders, with more comprehensive and intensive clinical/support services to reduce or prevent occurrences of de-compensation and/or crisis. Plans to establish regional jail-based outpatient services in selected local and regional jails continue. These services will directly assist inmates in these jails, help reduce civil census at Central State Hospital (CSH) by lowering the number of forensic admissions to its civil beds, and reduce length of stay for individuals on forensic status at CSH by assuring that appropriate jail-based monitoring and maintenance of treatment will occur upon discharge.

Locally CSBs/Authority continue to expand a variety of services to provide for longer term local needs of targeted consumers as they transition to community or to prevent crisis/hospitalization occurrences. These services include: specialized/living day support, intensive supportive residential, psychosocial rehabilitation, programs of assertive community treatment (PACT), intensive case management, and co-occurring disorder clinical interventions/supports.

Very structured and intensive regional census/utilization management of CSH civil beds successfully continues through the Regional Authorization Committee (RAC) which has representation from local CSBs/Authority, CSH and DMHMRSAS. The Reinvestment Project Manager will also serve on the RAC. With the closure of 2 CSH civil units between June-August 2003, resulting in a CSH bed capacity of 100, RAC activities continue to be more and more critical to reinvestment efforts.

The Region IV Partnership Planning Steering Committee held two Regional Public Hearings in late September to receive public input regarding system restructuring. Six stakeholder Focus Group Events had to be postponed due to Hurricane Isabel; these have been rescheduled for October. The Focus Groups are: Local Government, Mental Health, Mental Retardation, Substance Abuse, Hospitals/Providers, and Criminal/Juvenile Justice.

## Southern Region

**Regional Activities:** Reporting for the Southern Region, it appears that perhaps our plan may be somewhat more of an "investment" plan than a "reinvestment" plan. The rationale for this view is that most participants in our local planning effort considered the size of Southern Virginia Mental Health Institute (bed capacity) to be at a critical level and that any reduction in bed space would place the three CSB's in a precarious position given the lack of private beds and that two of the three CSB's do not receive any funds for payment of beds in private facilities - a critical component in current operations, let alone future considerations. Planning efforts in the Southern Region will await further directions from the Department.

## Northern Region

HPR II is continuing its efforts to improve services for persons with mental illness throughout the Region by carrying out an ambitious work plan through the Partnership Planning Process. All psychiatric hospitals and psychiatric inpatient units in Northern Virginia have participated in a follow up survey that help better identify the distinguishing characteristics of persons served in the various settings. This information will be used to clarify the respective roles of public and private providers. Plans are underway to begin training on the Recovery Model throughout the region and discussions are taking place with the private hospitals regarding a range of issues related to consent to treatment. Other topics being studied include: estimating the amount of funding needed to properly fund mental health services; how to establish community based services for persons Not Guilty by Reason of Insanity (NGRI); the implications of the projected closure of numerous private sector psychiatric beds; co-occurring disorders such as MR, SA and medical conditions; building the capacity for consumer operated programs and plans to continue the planning process after the first phase is completed. Plans are almost completed to transfer the fiscal agent responsibilities for private sector bed purchase and other related diversion and discharge assistance projects to the Fairfax-Falls Church CSB. Additional information regarding the activities in Northern Virginia can be obtained by going to the Partnership website at http://www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm.

## Regional Updates (continued)

### Far Southwestern Region

The Far Southwest Region has concluded five (5) regional partnership-planning conferences with very active participation from community stakeholders. Each conference included approximately 70 participants who listened to an overview of Reinvestment/Restructuring and then had the opportunity to share their feedback in small group settings. Seeking input from stakeholders in 17 counties gives an impression of the unique social and economic conditions that this region will be addressing in our planning. Our consumers have a compelling need for a broad array of services. These needs are complicated by a high rate of unemployment, families living below the poverty line at higher rates than state average, a high rate of uninsured and under-insured citizens, lack of primary health care in some areas and a lack of public transportation services. Stakeholder meetings from local medical and psychiatric facilities have also been scheduled as alternative plans for community-based treatment are discussed. The SWVA Behavioral Health Board is evaluating feedback from these conferences and written submissions. Thus far it is apparent that the consumers have consistent expectations of a service delivery system that responds in a holistic manner for both wellness/prevention based care and acute treatment. They also clearly expressed the need to continue state inpatient psychiatric services as a safety net.

The MR/MI program at the SWVTC has begun the process of admitting individuals into its specialized, short-term treatment program (90 days). The MR/MI council, composed of representatives from each CSB, SWVTC and SWVMHI, has exhibited the synergistic benefits from a region wide program in admissions screening, utilization review and case management. All involved are hopeful that this program will provide a much needed service to an underserved population.

Broader, more responsive access to emergency/crisis services with community interventions of transitional housing or respite care prior to hospitalization has been identified as a key concern. Expanding on existing community based services and developing new alternatives for treatment are complicated by a diffuse consumer population, lack of current funding and a community service care infrastructure that varies widely within the region. The latest planning conferences serve as evidence of our region's strong history of family and community involvement. Participants remarked often on their willingness to participate and effect a change for themselves, their families and the whole region. Restructuring is being seen as an opportunity as well as a challenge. Bridge funding will be required as seed money for any possible expansion of services.

### Northwestern Region

**Reinvestment**

The HPR I discharge process is moving along. There have been 22 discharges to date, with one of those having been readmitted. At the time this is being written, 4 additional people are on pass-to-discharge. The census at Western State over the past week has stayed in the mid-240s, which is near the number needed to close a unit.

The region is considering changing the program from plans to close two units to the closing of one unit this fiscal year. This may be necessary for two reasons: to make sure the resources are available to cover the cost of the discharges for the remainder of this year and for next year; and, to have some diversion money to assist with utilization management. Plans are in place to review progress at the end of the year and assess the possibility of closing another unit in the next fiscal year.

As for the ICF/MR, the application is in and the process is well underway. A public hearing is planned for Tuesday, October 28th at 7:15pm and will be held in the Board of Supervisors room of the Rockingham County Office Building. It is possible the ICF/MR will be approved in November. If all goes as planned, 6 consumers could be discharged to this facility in March. Meanwhile, A Western State social worker, the director of Community Support Services at Harrisonburg-Rockingham CSB and a representative of Pleasant View Homes are meeting regularly to develop innovative means for these consumers to spend time together while at Western State so that they can become acquainted.

The regions executive directors and Western State staff were scheduled to meet October 6th at Rappahannock-Rapidan CSB (RRCSB) in Culpepper at 10:30am. At this meeting, plans for the number of discharges to be supported by the region will be discussed. Utilization management strategies will also be discussed.

**Partnership Planning**

The Partnership Planning process has focused primarily on the regional concern about the availability of acute care psychiatric beds. The Public/Private Inpatient Psychiatric Care Forum is a spin off of the larger planning group. It met once in July and once in September. They have identified several issues requiring further investigation, such as regional utilization patterns and utilization management requirements. They also agreed on minimum data elements they would like to see on a regular basis. It was requested that the beginning data be compiled by participants and forwarded to Brian Duncan before the next meeting. The group will meet again October 31, 2003 at 10 a.m. at RRCSB in Culpepper. In addition to reviewing data, the group will identify members for a subcommittee that will be tasked with drafting regional utilization management practices.

## Regional Updates (continued)

### Catawba Region

***Catawba Regional Partnership~*** The Catawba Regional Partnership's goal is to develop and implement strategies to provide a more efficient, effective and accessible system of care, which includes both public and private sector treatment providers without sacrificing inpatient or outpatient treatment capacities.

The system of care addressed in this Partnership Planning includes Catawba Hospital, Blue Ridge Behavioral Healthcare, Alleghany-Highlands Community Services Board, and private providers in the region that have close linkages to the public mental health system, particularly Carilion Health Systems and HCA Lewis-Gale Hospital.

The Partnership Leadership Group for this project is composed of the Executive Director of Blue Ridge Behavioral Healthcare, Jack Wood, CEO of Catawba Hospital, Joe Sargeant, Executive Director of Alleghany Highlands CSB, Paula Mitchell, Vice President for Lewis-Gale Hospital Behavioral Healthcare, Rick Seidel, Director of Clinical Services at Carilion Roanoke Memorial Hospital, June Poe, representing the Roanoke chapter of the National Alliance for the Mentally Ill, and Diane Kelly, the Executive Director of the Roanoke chapter of the Mental Health Association.

Public and private providers and consumer and family stakeholder representation within the partnership leadership is critical…fully engaged and inside the tent.

We began meeting in the month of March.

Eight workgroups were established to address the following priority areas identified by the Regional Partnership: Treatment Process Across the Continuum of Care, Provision of Psychosocial Rehabilitation and Day Treatment Services, Development of Transitional Housing Options, Development of a PACT Program for Alleghany-Highlands CSB, Physician Resource Utilization, Centralized Pharmacy Services, Budget and Cost Revenue Analysis, Contract Development.

The Leadership Group formed workgroups at their May 30 meeting to address each priority area. Membership of these workgroups consisted of Catawba, Carilion and Lewis-Gale hospital staff, staff from Blue Ridge and Alleghany Highlands, and advocate and family representatives. Their charge was to review the existing services and to develop improved processes in their specific area.

The Regional Leadership met June 26 and heard presentations from all eight priority area workgroups.

After the completion of the workgroup reports in June, The Roanoke Chapter of the National Alliance for the Mentally Ill and the Mental Health Association of Roanoke Valley sponsored two Stakeholders Meetings held July 14 and July 17. 108 citizens attended these meetings and valuable feedback was received from consumers, family members and professionals after each workgroup presented a summary of their work.

The August 1 submission included many recommendations and modifications derived from the two Stakeholders meetings.

In addition to the strengths in the services systems the workgroups discovered significant overlaps as well as gaps in the services provided by current public and private treatment entities. They also found significant barriers in moving from one component of the treatment continuum to another, increasing the likelihood that individuals would not follow-through with sometimes vital services.

A critical outcome of this initial planning effort by the workgroups was the Team Building Process. The groups were chosen specifically for the purpose of getting the individuals together who would actually develop and implement blended programming and service coordination within the partnership.

These folks have known each other, but not as partners, only as arbiters and often gatekeepers at the boundaries of their respective organizations. In order for any of the Partnerships to succeed, a basic redefinition of the grass roots relationships must change. This is basic to the process. And seems to be off to a good start.

That was the process…

Now, the content. Numerous strategies were proposed to provide a more efficient, effective, and accessible system of care including both public and private sector treatment providers.

A few examples are:

- Develop a common medication formulary among all entities that participate in the treatment continuum. Discharge plans must be client-centered, with consumers and psychiatrists agreeing on what medications will be prescribed and the availability of medications established.
- Through comprehensive interagency treatment planning, including the public and private inpatient systems and the two boards, develop overarching long-range treatment goals with the consumer and whenever possible, the family.
- Utilize current CSB and hospital-based clinicians, including physician capacity, in the provision of treatment across settings creating a seamless system of staffing and services.
- To complement the previous two, expand existing utilization review processes that involve Catawba Hospital and Blue Ridge Behavioral Healthcare and medical staff peer review to incorporate staff from all treatment settings such as emergency room physicians and Carilion and Lewis-Gale Hospital staff.
- Establish a new day treatment "Bridges Program" provided in the Catawba Hospital Treatment Mall for recently discharged individuals to ease their transition back into a community-based living situation. This program would allow continued support in a familiar setting and with familiar providers until individuals could ultimately transition to a community-based psychosocial treatment program.
- Develop a "Roadmap to the Community, " to be used by consumers, families, and treatment providers seeking information on services available to consumers, how to access these services, pertinent contact and logistical information, and other resources such as entitlement benefits, housing, primary healthcare, and indigent pharmacy programs.
- Develop Transitional Housing, which will offer step-down or step-up residential services to adults who have been recently discharged from Catawba or who are at risk of inpatient admission. Such services do not currently exist in the

region and would require specialized funding.

- Develop a pilot program with 25 participants to demonstrate the effectiveness of specialized treatment services across public and private treatment settings for adults with co-occurring serious mental illness and substance abuse disorders.
- Develop a regional pharmacy to provide for quicker response to medication needs and increase efficiencies in the provision of pharmacy services. This would require the transfer of current and future funds allocated to the region from the Department's Hiram Davis Aftercare Pharmacy.
- Expand the region's array of community-based emergency and crisis services to give consumers' expanded treatment options in crisis situations
- Enter into a Memorandum of Agreement (MOA) with specific contractual language regarding service planning and billing. This MOA will include the purpose of the regional partnership; sections that address the roles and responsibilities of the partners; the vision and core values of the partnership; consumer, family member, and advocacy group involvement and participation; and system leadership, communications, accountability, and quality improvement expectations.
- Develop a reliable methodology to collect information regarding the value and cost of restructuring services to demonstrate "in hard dollars" the impact of the Partnership's restructuring plan.

To support these strategies, the Regional Partnership has recommended the following state-level actions necessary for the successful implementation of the plan.

- First, Review and adjust regulations, as necessary, to allow community and state facility staff to work interchangeably and to provide services that are reimbursable by DMAS. For example: License the Catawba Treatment Mall for community-based clients and seek a variance from DMAS, which currently prohibits state facility sited programs from billing State Plan Option Medicaid.
- Additionally, seek new funds for the proposed transitional housing proposal for two separate houses, one in Roanoke and one in Catawba, each accommodating 6 to 8 residents.
- And finally, transfer funds from the Hiram Davis Aftercare Pharmacy to consumers in the Alleghany-Blue Ridge catchment areas to the regional pharmacy budget annually. This would be under a contract that includes an escalator clause insuring continued increases that allow the pharmacy to remain viable. The region projects that once the pharmacy is fully operational, a small prescription fee, Medicaid reimbursement, and other operating efficiencies will offset some continuing costs.

The region recently had a Partnership breakfast at Lewis-Gale Hospital to kick off phase two of their efforts. They took a couple of months off to let Catawba focus on their JCAHO Accreditation.

***Regional CFS Partnership~*** Planning for the Child and Family Services Partnership got started a few months later than the adult partnership. It began with state and local advocates on July 5. The Steering Committee was formed and has met on four occasions to date.

The Regional Leadership Group will provide oversight for this process also. The CFS Steering committee membership includes representatives of the following private and public partnership organizations: Voices for Virginia's Children: Margaret Crowe, Senior Policy Manager; Roanoke Valley Alliance for Children; Mental Health Association of the Roanoke Valley, Diane Kelly; NAMI of the Roanoke Valley, June Poe; Roanoke County Schools; Roanoke County CPMT/ Parent Representative: Rita Gliniecki, Chair; Lewis Gale Center for Behavioral Health; Roanoke City Schools ; Alleghany Highlands CSB; BRBH: Gina Wilburn, CFS Director.

**Mission Statement:** To develop, advocate for and implement a single comprehensive system of care for child and family services

**Goals:**

1. To define the ideal CFS system of care
2. To identify strengths and challenges facing the CFS system of care in the community
3. To review existing research and community models to support development in the local and state CFS system of care
4. To make recommendations to enhance the community's current system of care
5. To identify the role of the Community Services Board within the community's CFS system of care

**Current Activities:** To date the following activities have been planned:

- Two public hearings are scheduled for October 28 and November 13 from 7:00 to 8:30 PM. The first hearing will be at Lewis Gale Education Center in Salem, VA and the second in the Botetourt Board of Supervisors Meeting Room. The Mental Health Association will moderate the first hearing and Margaret Crowe will moderate the second hearing. All comments will be recorded, transcribed and submitted in a report to the Leadership.
- A survey will be made available on the Voices for Virginia's Children web page for all area stakeholders. Notices will be mailed or given to public and private child-serving agencies/organizations.
- Margaret Crowe and Gina Wilburn provide representation to the State CFS Special Populations Workgroup.

**Barriers to the process:** The Steering Committee has, to date, identified several issues that include:

- Lack of clear directives for how the children's special populations efforts should be organized;
- Lack of information regarding how children's special populations work will fit into the larger reinvestment/restructuring outcome;
- Lack of consistency in the various regions in approaching the children's partnership process;
- Labor intensity of project and time constraints for members; and
- Lack of clarity about how dollars can be spent for activities planned.

## Eastern Region: A Message from a Medical Director

September 16, 2003

Dear Mr. Peratsakis, Mr. Favret (Coordinators of the HPR-V Reinvestment Project):

Governor Warner proposed mental health reforms for acute inpatient treatment last year, and the plan for reinvestment was developed by Commissioner Reinhard. The reforms were approved by the legislature this past spring. In HPR-V it initially allowed for closure of the admissions unit for acute care patients at Eastern State Hospital. The money saved from the closure of that unit would be provided to localities in HPR-V to provide for local acute care hospitalization and other community supports.

Of note, the National Association of State Mental Health Program Directors (NASMHPD) ranks states on a population-per-capita basis for state psychiatric hospital and community-based treatment. Currently, Virginia is ranked 7th for state psychiatric hospital costs ($38.80 with a mean of $25.58), and 41st for community-based treatment ($22.74 with a mean of $53.46).

There was initial opposition from some mental health advocates due to the need for "seed money" to prepare for the transition from state facilities to local hospitalization. That led to Governor Warner providing "bridge money" – not a lot, but definitely a start.

There has also been substantial opposition from the Eastern State Hospital medical staff. They have focused on the broad range of care from their treatment teams and questioned whether there would be similar care on the local level. They have also pointed out that deinstitutionalization of the seriously mentally ill did not measure up to initial expectations. To this point there has not been much public comment from the Medical Directors of the CSB's and departments within HPR-V. While concerns about the adequacy of funding persist, a very large majority of the Medical Directors are supportive of the Reinvestment Project in its present form. All are philosophically supportive of the direction of the Project.

The beds that are being discussed are acute care beds, not the longer term beds generally associated with deinstitutionalization. The goal of acute care psychiatric hospitalization is stabilization of a crisis, most commonly caused by medication noncompliance, substance abuse, or a crisis in the individual's environment. Quite frequently, the individual will have been receiving treatment from a treatment team in a local CSB, often over a number of years, and will be returning to that treatment team after discharge from a relatively brief hospitalization. Unfortunately, hospitalization outside the local level frequently contributes to inpatient and outpatient treatment teams functioning largely independently of one another. There is a liaison from each CSB to the hospital, but that individual does not usually have substantive influence. This can lead to major changes in the treatment regimen, which can be problematic when the individual returns to their outpatient environment. The optimum would be the closest continuity of care we can achieve.

In recent years, when the admissions unit has been full and when funds are available, Eastern State Hospital will purchase "local beds" in the community in lieu of going to the admissions unit. These hospitalizations have occurred relatively frequently when funds are available. There have not been significant problems with these hospitalizations that would differentiate them from Eastern State hospitalizations.

The failure of "deinstitutionalization" to live up to expectations refers primarily to individuals who had been hospitalized for a long time in state facilities. Usually the funds saved by discharge of state hospital patients were not made available, at least not totally, to the community. As a result, communities did not have the funds available to develop programs. However, the population we are discussing will be hospitalized locally, and frequently are in treatment at the local CSB. They are primarily being hospitalized to stabilize a crisis. If it turns out they cannot be treated locally in a relatively short specified period of time, they are transferred to Eastern State Hospital.

The local Medical Directors do have concerns about the project. A major concern is coordination of treatment during the time an individual is hospitalized, especially physician-to-physician contact. Physicians prescribe the medications, know what medications have been used in the past, and why they haven't worked. With the localities paying for the hospitalizations it is anticipated that time would be allotted for this necessary communication to take place. There are also concerns about sufficient funding for programmatic services, including adult homes, active day programs, case management, and MHSS services to provide aggressive means of keeping people out of the hospital and on medications, and to provide further stabilization once they are discharged from the hospital.

Despite our concerns, we are strongly in support of the Reinvestment Project. We recognize the shift to local hospitalization as being a first step, allowing for less dislocation for individuals being hospitalized, and for improved communication, collaboration, and integration of treatment. We expect the first step to be followed by more innovative programs to aggressively treat individuals before getting to the point of needing hospitalization. Currently, most CSB's do not have the resources available to develop crisis stabilization units. If CSB's are paying for local hospitalization, and crisis stabilization units will help avert hospitalization, then the likelihood of developing such units increases dramatically. The resources for paying for hospitalization and planning for and providing services for stabilization will all be coming from the same pool. Given those incentives, there will be fertile ground for further innovative programs.

Sincerely,

**James M. Laster**

James M. Laster, M.D., M.P.H.
Medical Director
Virginia Beach Department of MHMRSAS

cc: James Reinhard, M.D.

## Establishment of a Restructuring and Reinvestment Website: http://www.dmhmrsas.state.va.us/R&R/defaultR&R.htm

The Department has recently developed a website to highlight state-wide Restructuring and Reinvestment initiatives. This new website is hosted on the Department's main website at:

http://www.dmhmrsas.state.va.us/R&R/defaultR&R.htm.

The website was developed for your use and belongs to you. While still an infant site, we hope to nurture and expand the site to suit the needs of the individuals using it. The site currently contains the following information:

**Partnership Press**

All issues of the Partnership Press are available in PDF and text-only (screen-reader friendly) versions. Please feel free to print and freely distribute copies to interested parties.

**Activities Calendars**

Monthly Activities Calendars are available with hyperlinked activities. Each activity/meeting is linked to a form with general information about the activity, including activity/meeting title, contact person, convener, contact phone number, location, date and time. Some locales are developing their own calendars and will have links posted at this site. ***PLEASE submit any open meetings for inclusion on the calendar. To submit a meeting, e-mail all of the information listed above to: satwell@dmhmrsas.state.va.us.***

Please check back often as new information will be added frequently!

**Regional Reports**

The Regional Reports are available and are listed by Health Planning Region. Some regions have included additional media such as PowerPoint presentations.

**Restructuring Policy Advisory Committee (RPAC)**

The RPAC is comprised of the Regional Leadership and Special Populations Workgroup leaders. This group meets regularly to share information and guide the Restructuring and Reinvestment initiatives. Information on past and future meetings will be available as the site continues to develop.

**Special Populations Workgroups**

Five Special Populations Work Groups have been developed:

- Child and Adolescent Population Work Group
- Mental Retardation Work Group
- Substance Abuse Population Work Group
- Gero-Psychiatric Population Work Group
- Forensic Population Work Group

These five Work Groups will make recommendations for consideration by the Regional Partnership Planning Committees and the Restructuring Policy Advisory Committee. The Work Groups will also make short-term (August 2003) and long-term (August 2004) recommendations to identify policy, legislative, administrative, funding and service development actions that may enhance service systems for special populations consumers (e.g. capacity building, training needs, administrative procedures). The Work Groups will present regularly to the RPAC; Work Group memberships, presentations and materials will be made available on the website in the near future.

## DMHMRSAS Welcomes Frank L. Tetrick, III, Assistant Commissioner

Commissioner James S. Reinhard, M.D. announced in September that he had hired Frank L. Tetrick, III, as Assistant Commissioner for Community Services, a key leadership position that includes supervision of the mental health, mental retardation and substance abuse program offices at the Department. "Frank Tetrick strengthens the leadership of the Department to achieve our goal of further developing the system of community-based mental health, mental retardation and substance abuse services. Over the past year, he has been an invaluable asset in steering the Department's primary initiatives to restructure the services system and to reinvest facility resources into community programs. Frank took a lead role in helping create the current Partnership Agreement section of the Performance Contract with the Community Services Boards, a document that reinforces the value of a collaborative working relationship." Mr. Tetrick began working at the Department on October 6.

Mr. Tetrick has served as the Executive Director of the Middle Peninsula - Northern Neck Community Services Board (MPNNCSB), in Saluda, since April, 2000. During his tenure as Executive Director, Mr. Tetrick directed a comprehensive program of community-based prevention, early intervention, mental health, mental retardation and substance abuse services to residents of the ten counties comprising the Middle Peninsula and Northern Neck, a population of 137,000. In addition, since 2001 Tetrick served as the Health Planning Region V (HPR-V) Chair for nine community services boards that comprise the region. Tetrick also served as co-leader of the HPR-V Reinvestment Project that targets a phase-down of acute care at Eastern State Hospital, allowing for the transfer of facility operating funds for development of local and regional community-based services. In this role, Tetrick served as the principle spokesperson for the project in regional and state-wide meetings. He was elected to serve as Chair of the Executive Directors Forum for the Virginia Association of Community Services Boards (VACSB) for 2004, representing all of the member CSBs in Virginia.

Tetrick holds a Masters degree in Counseling and an undergraduate degree in Business Administration from Marshall University in Huntington, West Virginia. He lives in Irvington, Virginia with his wife Mary Ellen.

***DMHMRSAS extends a warm welcome to you, Mr. Tetrick!***

## Regional Leadership

### ***Central Region:***

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**Vickie Yesbeck Montgomery**, Acting Director
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### ***Catawba Area:***

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### ***Eastern Region:***

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### ***Northern Region:***

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**Lynn DeLacy**, Director
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### ***Northwestern Region:***

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### ***Southern Region:***

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### ***Far Southwestern Region:***

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